

Navy Medicine
Best Business Practice Submission Guide

Table of Contents

I. Introduction	2
II. Frequently Asked Questions	3
III. Best Business Practice (BBP) Submission Process	6
IV. References	9
V. Users' Self-Assessment Form	10

Navy Medicine Best Business Practice Submission Guide

I. Introduction

What do we mean when we refer to “Best Business Practices” within Navy Medicine? Where do we find them? How do we share them? How do we know they are “best?” The senior leaders of Navy Medicine have adopted the following definition of a Best Business Practice (BBP): “a practice that has been shown to produce superior results; selected by a systematic process; and adapted to fit a particular organization.” This last aspect is especially important, because the diversity of our organization usually precludes a “one size fits all” approach. Our fiscal realities dictate that we derive the best value per dollar spent through the application of BBPs.¹

The goal of the BBP initiative is to identify, evaluate, and proliferate best practices in support of Navy Medicine’s mission of Force Health Protection and focus on Readiness, Optimization and Integration. In addition BBPs should “result in best value, indicated by increased market share, reduced cost, reduced cycle time, improved quality, increased productivity, and/or return on investment.”²

There are several potential sources of BBPs. Generally, there are three broad categories of sources: (1) “Top-Down” sources that may be identified by corporate headquarters; (2) “Bottom-Up” sources that are generated from field activities/commands; and (3) “Lateral” sources that may come from professional literature, industry experts such as the Healthcare Advisory Board, Best Practice Network, Web searches, etc. The identification and evaluation process will consider all of these sources.

The categories outlined in the BBP Summary in Section 3 and the Users’ Self-Assessment Form outlined in Section 5 are consistent with the Approach, Deployment, and Results format used in the Malcolm Baldrige National Quality Award criteria and our Medical Inspector General’s team. The criteria include elements of existing tools such as Navy Medicine’s Business Case Analysis; Evidence Based Healthcare Analysis, and the Alignment and Integration Model.

Navy Medicine will focus on developing, identifying, implementing and evaluating BBPs. In developing this guide, we have researched the process for identifying and proliferating BBPs that have been implemented by other large public and private healthcare systems such as the Department of Veterans’ Affairs and Tenet Healthcare.

II. Frequently Asked Questions

1. How will Navy Medicine distinguish BBPs from good ideas?

While there are several definitions for “BBPs” from a selection of sources and Web sites, based upon the depth and breadth of these definitions, the Navy Medicine definition for “BBPs” is still relevant. An important element of all definitions is the concept that BBPs are evaluated processes that have been proven successful. Thus, not every good idea is necessarily a BBP. In order to strike a balance between encouraging participation from the field and making the evaluation process rigorous enough to support designation as a BBP, our research suggests a progression of three designations to differentiate good ideas from true BBPs. Navy Medicine designations are:

- (a) Everyday Innovation:** creative thinking and skills applied to practical issues. Progress achieved through small, incremental improvements, often ingenious in their design, though limited in scope. There is informal evaluation and documentation. These innovations in healthcare delivery should not be underestimated. By removing the obstacles that hinder the efficient delivery of information and services, they enhance the important work of Navy Medicine.
- (b) Promising Practice:** fully implemented programs that positively have affected healthcare delivery, improved operational efficiency or provided creative sustainable solutions to stubborn problems. Project results have been formally evaluated and documented but have not met the criteria for sustained superior performance.
- (c) BBP:** innovations that have been shown to produce superior results; selected by a systematic process; and adapted to fit a particular organization. These are fully implemented programs, benchmarked and tested, which meet or set new standards or introduce dramatic innovations which result in “best value as indicated by increased market share, reduced cost, reduced cycle time, improved quality, increased productivity, and/or return on investment”.

2. How do BBPs relate to protocols, guidelines, standards, or clinical pathways?

A protocol is an organized method of analyzing and dealing with a disease process or symptom complex. A protocol may be highly organized and directive, as in some algorithms, or it may be more general and flexible. The type selected for development and use will depend on the clinical practice situation, the education and experience of those who will be using the protocol and the availability of physician support. A minimally trained person who has limited physician availability will require a protocol that is very explicit, whereas, a more highly trained professional may require only general guidelines.³

A guideline reflects the state of current knowledge, as published in healthcare literature, regarding the effectiveness and appropriateness of procedures or practices.⁴ The goal of guidelines is to describe a recommended course of action for a specific condition, procedure, or patient population.⁵

A standard is a statement that defines the performance expectations, structures, or processes that must be substantially in place in a healthcare organization to enhance the quality of care.⁶

A clinical pathway is a tool designed to optimally sequence and coordinate events or interventions to reduce delays, promote efficient resource use, and improve quality or performance.⁷

Any one of these may be a “best practice”. It may also be designated as a “BBP” if it has been shown to produce “best value indicated by increased market share, reduced cost, reduced cycle time, improved quality, increased productivity, and/or return on investment”.

3. What is the difference between benchmarks and benchmarking?

Benchmarks are the actual measurements used to gauge the performance of a function, operation, or business relative to others.⁸ Benchmarking is the continual and collaborative discipline of measuring and comparing the results of key work processes with those of the best performers. It is learning how to adapt BBPs learned through the benchmarking process that promotes breakthroughs in process improvements and builds healthier communities.⁹ The objective of benchmarking is to identify BBPs so that an organization can set higher goals and improve performance.¹⁰ Comparing benchmarks can do this.

4. How does benchmarking relate to BBPs?

Benchmarking is understood to be a process, a structured approach, and a discipline that is continuing or ongoing. It involves measuring, evaluating and comparing both results and processes that produce the best results.¹⁰ From those identified best results, we strive to learn about the strategies and practices that produced those best results. Those practices are known as BBPs. The overall goal of benchmarking is to identify BBPs that can be implemented to produce improvements that are at least at the same level of the best.

5. What is the difference between evidence based practice and a BBP?

Evidence based practice involves rigorous scientific evidence to demonstrate clinical effectiveness. BBPs can be evidence based, but can also be innovative, meaning a new way of doing something that results in “best value indicated by increased market share, reduced cost, reduced cycle time, improved quality, increased productivity, and/or return on investment.” For example, the development of a program to teach children asthma self-management using a Nintendo computer game. The information is evidence-based and supported through scientific research, but the modality for delivering the information is innovative. If the use of computer games to teach asthma management techniques results in a more satisfied customer, reduced costs due to better compliance and fewer emergency department visits, and a positive return on investment, then this may be considered a BBP in teaching asthma management.¹¹

III. BBP Submission Process

1. Prepare your BBP Summary, following the instructions below.
2. Submit your BBP Summary via the Web at <http://bumed.med.navy.mil/med08/bestpractices/bestPractices.htm> or via E-mail to Elugo@us.med.navy.mil.
3. Work interactively with BBP consultant to insure completeness.

Preparing the BBP Summary

Complete the BBP summary by answering each item in the following sections. If a section is not applicable, a statement summarizing why must be included in the report. Submit a brief document including the following: background, goals and objectives, approach, deployment, results and bibliography. Once the BBP consultant receives your summary, the consultant will partner with you to develop your submission to the highest Navy Medicine designation (Everyday Innovation, Promising Practice or Best Business Practice).

A comprehensive BBP Summary should address the following:

1. Background:

- A description or diagram of the program, service, function, or process that you are submitting as a BBP.
- Purpose of developing the program, service, or function.
- A description of the problems, needs, or deficiencies that led you to work on this area.
- A timeline for the planning and implementation of the program to date.

2. Goals and Objectives:

- A description of the quantifiable goals and objectives for the program.
- Evidence of alignment with your Command's strategic goals and objectives and Navy Medicine's mission of Force Health Protection and focus of ROI.

3. Approach:

- A description of how leadership, champions, customers, and other departments or services were involved in the program design or development.
- A description of how feedback was used to develop or make improvements in the program?
- A table of program metrics with baseline (if available) and targets. The dimensions for these metrics might include increased market share, reduced cost, reduced cycle time, improved quality, increased productivity, return on investment, or any other outcomes that positively benefit the user.
- A description of the methods of analysis used to support the assessment and development of the program. Examples of these methods of analysis include but are not limited to a)

evidence-based; b) fact-based; c) comparison-based (benchmarking); d) literature-based; e) business-case; or f) any other important information which supported the assessment and development of the program. This information could be summarized in flowchart form.

- A description of gaps between your program and results of the analysis above that became areas of focused improvement work.
- A summary of any other networking that occurred for the purpose of data collection, analysis, information gathering, or clarification.

4. Deployment:

- A summary of the implementation plan.
- A listing of data sources and methods used to ensure accuracy and consistency of data.
- Objective evidence that baseline data was collected and analyzed.
- Any protocols, guidelines, or tools used to evaluate the program. May be included as attachments. Examples may include Navy Medicine's Business Case Analysis, Evidence Based Healthcare Analysis, or Optimization Tool Kit.
- A matrix describing the categories of resources (e.g., manpower, equipment, facilities, and money) required to support program implementation and sustainment, compared with baseline data.

5. Results:

- A summary of the results, including how benchmarks were met or exceeded. Consider increased market share, reduced cost, reduced cycle time, improved quality, increased productivity, return on investment, or any other positive outcomes.
- In summarizing your results consider the following:
 - A description of the system or framework used to evaluate the outcomes or benefits to include data collection and analysis. Provide graphs, data, or other supportive documentation.
 - Trends and product/service performance measures showing excellent improvement over a minimum three-month period.
 - Documentation that results have not adversely affected other Command goals and objectives programs or services.
 - A description of any secondary benefits from the program.
 - A description of the applicability and transferability of this program to other organizations, communities, etc.

6. Bibliography or Reference List.

- Bibliography of literature used to develop the program improvements and a reference list for any other materials, Websites, expert opinion, conferences, etc. used to develop your BBP Summary.

IV. References

1. Navy Surgeon General's SITREP, Best Business Practices, 17 August 1999.
2. Navy Medicine Strategic Plan, August 2000.
3. Hudak, C. M., Redstone, P., Hokanson, N. & Suzuki, I. (1976). Clinical Protocols: A Guide for Nurses and Physicians. Philadelphia, PA: J.B. Lippincott Company, 3.
4. Marek, K.D. (1995). Manual to develop guidelines. Washington, DC: American Nurses Association.
5. Research, Public Health Service, U.S. Department of Health and Human Services. Prediction and Prevention. Clinical practice guideline. AHCPR Publication No. 92-0047. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services.
6. Smith-Marker, C. (1987). Setting Standards for Professional Nursing: The Marker Model.
7. Lovejoy, L., Bussey, C. & Sherer A.P. (1997). The path to a critical pathway: Collaborative care for ostomy patients. Journal of WOCN.
8. Bogan, C. & English, M. (1994). Benchmarking for Best Practices. McGraw-Hill, Inc.: New York, NY.
9. Gift, R. G. & Mosel, D. (1994). "What Is Benchmarking?" Benchmarking in Health Care: A Collaborative Approach. New York, N.Y.: American Hospital Association Publishing, 1994.
10. Czarnecki, M. (1996). "Benchmarking: A Data-Oriented Look at Improving Health Care Performance," J Nurse Care Qual, 10(3), 1-6.
11. Deighan, M. & Boyd, K. (1996). "Defining evidence-based health care: A Health-Care Learning Strategy." NT Research, 1(5), 332-339.
12. Sackett, D., Rosenberg, W. & Gray, M. (1996). "Evidence-based Medicine: What it is and What it isn't -- It's About Integrating Individual Clinical Expertise with the Best External Evidence." British Medical Journal, 312, 71-72.
13. The Best Practice Network (1998). www.best4health.org

V. Users' Self-Assessment Form

Because there are different best practice designations, it is helpful for the person submitting the document, to self-assess the strength of the BBP Summary prior to sending the document to BUMED's BBP consultant. Please use the following self-assessment form to:

- Review your BBP Summary.
- Evaluate your BBP Summary report in light of each of the five Evaluative sections in Part A, below. References in bold italic (i.e. **See section 1**) refer to the numbered sections in the body of *your* BBP Report.
- Select the point category that most closely matches your evaluation and record in the score column on the left.
- Enter the total of your scores for all five sections in Part B – Cumulative Score.

Part A – Evaluative Sections

1. Background. *See section (1).* Score: _____

Score	Points	Criteria
	0	There is no description of the program, purpose, needs, or timelines.
	1	The program is described with major gaps in information about purpose needs, and timelines.
	4	The program is described with minor gaps in information about purpose, needs, and timelines.
	5	The program description addresses purpose, needs, and timelines clearly and succinctly.

2. Goals and Objectives. *See section (2).* Score: _____

Score	Points	Criteria
	0	The are no goals or objectives identified or the goals and objectives are identified but are not quantifiable or do not match the purpose of the program.
	3	The goals and objectives are clearly defined and measurable but are not aligned with the strategic goals and objectives of the Command.
	12	The goals and objectives are clearly defined, measurable, and are aligned with the strategic goals and objectives of the Command.
	15	The goals and objectives are clearly defined, measurable, and aligned with the strategic goals and objectives of both the Command and Navy Medicine.

3. Approach

3a. Approach. *See Section (3).* **Score:** _____

Score	Points	Criteria
	0	The approach described is fragmented, uncoordinated, and anecdotal. There are major gaps in the coordination, design, and assessment used to support the development of the program.
	4	The approach is still in the early stages of development. There are minor gaps in the coordination, design, and assessment used to support the development of the program.
	16	The approach is strong but moderately coordinated. It is dependent on one or a few individuals. Metrics are identified, measurable, and support the goals and objectives. The approach includes strong evidence of a systematic approach to the coordination, design, and assessment used to support the development of the program.
	20	The approach is strong, systematic, and fully coordinated. It is supported by the leadership, the target community, and has an identified program champion. It has been fully coordinated across interdisciplinary, geographic, interdepartmental or interagency boundaries. Metrics are identified, measurable, and support the goals and objectives.

3b. Method of Analysis. What kinds of information, research, and analysis were used in the assessment of your program? *See section (3).* **Score:** _____*

Score	Points	Criteria
	0	None
	5	<ul style="list-style-type: none">• Evidence-based healthcare analysis (incorporates healthcare research or healthcare processes).• Fact-based analysis (integrates opinions of respected authorities, clinical experience, descriptive studies, reports of expert committees)• Comparison analysis (uses benchmarking processes, comparison to established national or published standards)• Literature based analysis (integrates published research)• Business-case analysis (integrates key financial information and ROI)

4. Deployment. *See section (4).* **Score:** _____

	0	The program has been only partially implemented. There are major gaps in the plan concerning personnel involved, the source, and accuracy of data used to establish baseline data, tools used to evaluate the plan, or resources required to fully implement and sustain the plan.
	4	The program has been fully implemented for less than 6 months. There are minor inconsistencies in the plan but corrective actions have been identified and are underway.
	16	The program has been fully implemented for at least 6 months. The implementation plan is complete and there is initial documentation of positive results as related to the identified goals, objectives, and metrics.
	20	The program has been fully implemented for at least 12 months and there is documentation of consistent positive results as related to the goals, objectives, and metrics.

5. Results.

5a. Results. *See section (5).* **Score:** _____

Score	Points	Criteria
	0	There is no description of the system or framework used to evaluate the outcomes. There is little or no evidence to support improved performance. Evidence indicates unacceptable adverse impact on other Command goals, objectives, programs, or services.
	21	The evidence demonstrates less than 15% improvement over the baseline metrics or 15% or more improvement for a sustained period of less than 6 months.
	24	The evidence demonstrates a 15% or more improvement over the baseline metrics for a sustained period of at least 6 months.
	30	The evidence demonstrates a 15% or more improvement over the baseline metrics for a sustained period of least 12 months.

5b. Applicability. Could this is program be applied in other healthcare organizations and settings? *See section (5).* **Score:** _____

Score	Points	Criteria
	0	The program described has no obvious application to other environments. Its scope is very narrow, or it is focused on reaction to a very specific problem or anecdotal situation.
	1	The program described has minimal applicability to any other healthcare environment. It is highly specialized or niche-oriented program.
	4	The program described is moderately applicable to other like healthcare environments.
	5	The program described is widely applicable and adaptable to a variety of healthcare environments.

DO NOT SUBMIT THIS FORM! THIS IS FOR INTERNAL COMMAND USE ONLY!

Part B – Cumulative Score: _____

Category	Points	Criteria
Everyday Innovation	70-80	Creative thinking and skills applied to practical issues. Progress achieved through small, incremental improvements, often ingenious in their design, though limited in scope. There is informal evaluation and documentation. These innovations in healthcare delivery should not be underestimated. By removing the obstacles that hinder the efficient delivery of information and services, they enhance the important work of Navy Medicine.
Promising Practice	81-94	Fully implemented programs that positively have affected healthcare delivery, improved operational efficiency or provided creative sustainable solutions to stubborn problems. Project results have been formally evaluated and documented but have not met the criteria for sustained superior performance.
BBP	95-100	Practices that have been shown to produce superior results; selected by a systematic process; and adapted to fit a particular organization. These are fully implemented programs, benchmarked and tested, which meet or set new standards or introduce dramatic innovations which result in “best value as indicated by increased market share, reduced cost, reduced cycle time, improved quality, increased productivity, and/or return on investment”.

Double click to open the spreadsheet below and fill in the appropriate score to determine the initial category of your submission. For any scores below 70, please give us a call.

	Score
Background	0
Goals and Objectives	0
Approach	0
Method of Analysis	0
Deployment	0
Results	0
Applicability	0
Total Score	0